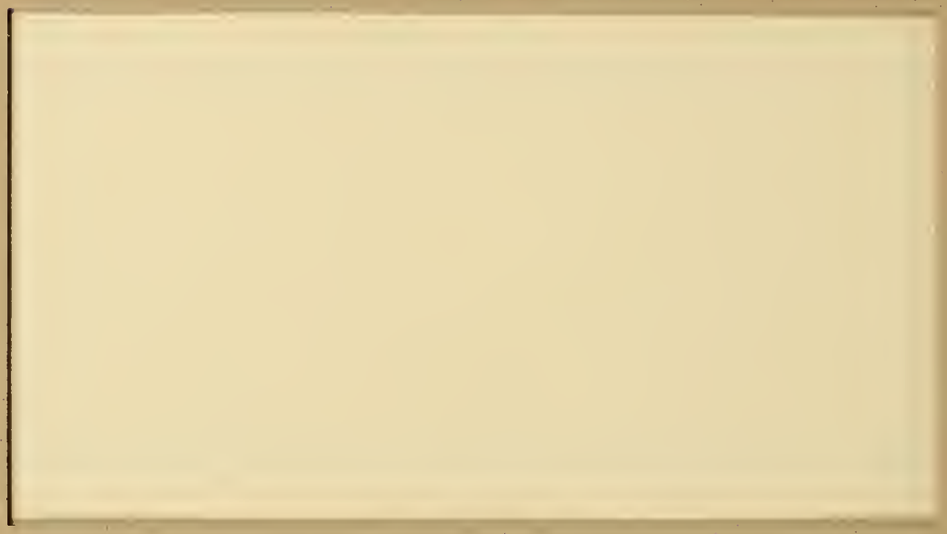
AMERICAN INDIAN HEALTH SERVICES AND STATE HEALTH REFORM

RURAL HEALTH RESEARCH CENTER

Division of Health Services Research and Policy
School of Public Health
Box 729
420 Delaware Street S.E.
Minneapolis, MN 55455-0392

UNIVERSITY OF MINNESOTA



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Ira Moscovice, Ph.D
University of Minnesota
Rural Health Research Center
Division of Health Services Research and Policy
School of Public Health
Box 729
420 Delaware Street S.E.
Minneapolis, MN 55455-0392

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David Hartley, Ph.D.

Rural Health Research Center
Institute for Health Services Research
School of Public Health
University of Minnesota

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

The purpose of this paper is to provide an overview of the way in which health services are provided to American Indians in rural areas of Minnesota under federal and tribal programs, and to discuss how provision of services is currently changing under Minnesota's health reform legislation. The Minnesota experience may have implications for other states that attempt to integrate Indian health services with health care reform.

The Indian Health Service (IHS) has administered American Indian health care programs since 1955. Charged with the responsibility of improving the health status of American Indians and Alaska natives, IHS provides a comprehensive range of inpatient and ambulatory services for approximately one million eligible Indians. Indian health services are provided by IHS under three different arrangements: direct service provision, contracting, and self-governed direct service provision.

All Minnesota Indian tribes rely on private sector contracting for much of their inpatient care. Because the Minnesota tribes rely so heavily on private sector contracts, it is necessary to reconcile the needs of the Indian health care delivery and financing systems with the requirements of state-level health care reform.

In 1992, the Minnesota legislature passed the first iteration of state health care reform known as MinnesotaCare. It established a new insurance plan for low income persons without health insurance. In 1993, the state required all providers to form integrated service networks (ISNs) by July 1, 1997 for the purpose of arranging for and financing health services for a defined population at a fixed price. In 1994, the legislature created community integrated service networks (CISNs) intended to give small ISNs in rural areas a competitive advantage over larger, urban ISNs by allowing them to form three years in advance of "regular" ISNs.

When fully implemented, both the insurance aspect of MinnesotaCare and the formation of ISNs and CISNs may have an impact on health services delivery for American Indians living in Minnesota. MinnesotaCare health insurance may help provide relief to underfunded tribal health centers and the synergistic effect of networking through ISNs or CISNs may lower costs, increase access, and improve quality of services.

While the pace of health care reform in Minnesota has slowed somewhat, some Indian bands in Minnesota are proceeding to collaborate with non-Indian health care providers in ways that might yield future benefits as MinnesotaCare is more fully implemented. For example, the Mille Lacs band of Ojibwe have been instrumental in the formation of a network with several regional providers (physicians and hospitals) and the University of Minnesota Department of Family Practice and Community Health to provide prevention, wellness, primary care, inpatient, ambulatory and long-term care services in a convenient, humane and culturally-sensitive manner.

In contrast to the efforts of the Mille Lacs band, the Leech Lake band of Ojibwe have been less aggressive in their networking activity. Comparing the networking activities to date of the two bands, we conclude:

- Networking of Indian and non-Indian health services is enhanced if Indian groups have experience operating their own health services and are familiar with area providers;

- Involvement of non-local entities such as a tertiary care hospital or an academic institution can help identify resources and establish contacts with area providers; and

- Despite their potentially greater need, geographically isolated reservations may have greater difficulty developing network relationships than those in less remote regions.

INTRODUCTION

The health service needs of Native American people living in rural areas have not traditionally been viewed as a rural health issue. In part, this is due to the role federal agencies, such as the Indian Health Service, have played in providing health services to American Indians. Federal financing and provision of services coupled with the recruitment and placement of practitioners appeared to insulate American Indians from some of the health services delivery problems of other rural populations. In fact, rural tribal health service delivery has much in common with rural health service delivery in general. For example, problems associated with providing access to high quality care in remote locations are common to both.

Recent assessments of the impact of state and federal health reform on rural areas have found that integration of services has the potential to improve access and quality for rural residents (Christianson and Moscovice, 1993). This paper reports on efforts to integrate tribal health services with other non-Indian health service providers. These efforts are illustrated by the example of a Minnesota tribe that has served as a catalyst in the formation of a network that provides prevention, wellness, primary care, inpatient, ambulatory, and long term care services in communities adjacent to the major highway that connects Duluth and the twin cities of Minneapolis and St. Paul, Minnesota.

The purpose of this paper is to provide an overview of the way in which health services are provided to American Indians in rural areas of Minnesota under federal and tribal programs, and to discuss how provision of services is currently changing under Minnesota's health reform legislation. The Minnesota experience may have implications for other states that attempt to integrate Indian health services with health care reform.

INDIAN HEALTH SERVICE PROVIDER ARRANGEMENTS

The Indian Health Service (IHS) was created in 1955 when the responsibility for American Indian health care was transferred from the Department of the Interior to the Department of Health, Education and Welfare and assigned to the U.S. Public Health Service. The original goal of the Indian Health Service was to eliminate infectious diseases. In 1976, the mission expanded from one of disease prevention to improving the health status of American Indians and Alaska natives. IHS is now responsible for providing a comprehensive range of inpatient and ambulatory services for approximately one million eligible Indians. To be eligible for IHS direct care services, one must be "of Indian descent or belonging to the Indian community served by the local facilities and program" (OTA, 1986). Indian health services are provided under three different arrangements: direct service provision, contracting for direct service provision, and self-governed direct service provision.[1]

Direct Service Provision

Originally, all Indian health services were provided directly by federal staff in IHS-owned and operated facilities. Many of these facilities still exist. They are supervised by IHS area offices in twelve regions: Aberdeen (SD), Alaska, Albuquerque (NM), Bemidji (MN), Billings (MT), California, Nashville (TN), Navajo, Oklahoma, Phoenix (AZ), Portland (OR), and Tucson (AZ). In Minnesota, the IHS operates an ambulatory care clinic at White

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[1] In cases where neither the IHS nor the tribe can provide care directly, the "Contract Health Services" program allows reimbursement to private providers on a pre-approved, priority basis. Eligibility for contract services is somewhat more restrictive than eligibility for direct care services. To be eligible for services, a person must live on a reservation or live in a county adjoining a reservation and be a member of the tribe or have social or economic ties to the reservation. Of 50,000 American Indians living in Minnesota, 25,000 qualify for contract services.

Earth and small hospitals and ambulatory care clinics at both Red Lake and Leech Lake. These direct services are operated by the regional IHS office in Bemidji.

Contracting for Direct Service Provision

The Indian Self-Determination and Education Assistance Act of 1975 (PL 93-638) offered Indian tribes the opportunity to assume management of programs operated by the Bureau of Indian Affairs and IHS. This arrangement is commonly referred to as "638 contracting". Under the act, a tribal contractor is entitled to receive funding equivalent to the amount that the IHS would have spent had IHS provided the service directly. Tribes may use 638 funds to operate their own clinics, or to purchase services from area providers. The area IHS offices do not manage 638 contracted services, but they continue to monitor the services provided. In addition, the IHS regional offices assist tribal governments to develop their management systems and skills.

Some traditional, reservation-based tribes have not been active in 638 contracting. For example, in 1984, 638 contracting accounted for less than two percent of all outpatient visits for the Navajo area in the southwest region of the U.S. In the Bemidji area, on the other hand, 638 contracting was more prevalent, accounting for 70 percent of outpatient visits in 1984, and increasing in recent years. In Minnesota, seven of the eight reservations whose health services are not directly provided by IHS contract for services under 638 authority.

A federal program intended to help improve the fiscal viability of health care organizations in underserved areas may provide another source of non-IHS funds for tribal health services (Travers and Ellis, 1992). Reservations operating clinics under the 638 contracting arrangement automatically qualify as Federally Qualified Health Centers

(FQHCs), making them eligible for cost-based reimbursement for Medicare and Medicaid services. An obstacle to this funding stream is the fact that some tribes do not have adequate billing mechanisms. With the help of the Minnesota Office of Rural Health and Department of Human Services staff, technical assistance workshops have been held with tribal health administrators to assist them in developing billing proficiency. The Fond du Lac band has improved its accounting capabilities sufficiently to begin billing Medicaid and Medicare as an FQHC. Changing traditional accounting methods to enable cost-based billing continues to be an obstacle for other bands.

Self-Governed Direct Service Provision

A third option for reservations to operate their own health services was made possible by the Self-Governance Demonstration Project, authorized in 1988 by Title III of the Indian Self-Determination and Education Assistance Act Amendments (PL 102-573, Sec.302). This project allows reservations to expand their autonomy in the operations of any services and functions administered by the Bureau of Indian Affairs or the Indian Health Service. To apply for self-governance status, a tribe must have previous experience with contracting. The tribe negotiates directly with the federal agency to receive funds that would otherwise pass through the regional office. Since the IHS area office is no longer responsible for administrative oversight, the tribe's share of administrative overhead is allocated directly to the tribe, although it may then choose to "buy back" administrative services from the IHS area office. In Minnesota, the Mille Lacs band of Ojibwe has recently negotiated a self-governance compact with the director of the IHS.

HEALTH CARE REFORM IN MINNESOTA

All 11 Minnesota tribes rely on private sector contracting for much of their inpatient care, including all surgery and obstetrics. Because the Minnesota tribes rely so heavily on private sector contracts, it is necessary to reconcile the needs of the Indian health care delivery system with the requirements of state-level health care reform.

In 1992, the Minnesota legislature passed the first iteration of state health care reform known as MinnesotaCare. In part, MinnesotaCare established a new insurance plan for those with annual incomes between the level of Medicaid eligibility and 250 percent of the federal poverty level. To become eligible, an individual must have been uninsured for at least four months, be unable to obtain employer-paid health insurance for at least 18 months, and meet income guidelines.

In 1993, the legislature expanded the original law. The 1993 bill required the formation of integrated service networks (ISNs) "...that will be responsible for arranging for or delivering a full array of health care services, from routine primary and preventive care through acute inpatient hospital care, to a defined population for a fixed price from a purchaser" (Minnesota SF900, 4/19/93). Providers who choose not to join an ISN, will be subjected to a regulated all-payer system to control costs and utilization. These two mechanisms, the ISN and the all-payer system, are expected to control rising health care costs while maintaining or improving the quality of services.

Recognizing that community-based ISNs may have merit, the legislature adopted a number of provisions to encourage the formation of small, rural ISNs and to help overcome barriers to their development. In 1994, the Minnesota legislature defined community integrated service networks (CISNs) as networks limited to serving populations

with no more than 50,000 members. They would be licensed a full three years before the first ISNs are licensed, giving them protection from competition with other ISNs during the early stages of their development. They will be subject to the licensure requirements currently in place for HMOs, with the following exceptions:

- At least 51 percent of the members of the governing body must be residents of the CISN's service area;
- CISNs may make use of accredited capitated providers (ACPs) to satisfy up to 30 percent of their net worth requirements. ACPs are capitated providers in the CISN that agree to provide services, without compensation, to enrollees of an insolvent CISN for up to six months after the ISN has been declared insolvent;
- CISNs must offer the HMO benefits currently required of HMOs, except that they may make benefits available with individual deductibles of up to $1,000;
- CISNs are exempt from current HMO administrative requirements, including: maintaining certain statistics; filing provider contract forms; written quality assurance plans; preparation and filing of marketing plans; reporting of changes of provider addresses; and "focused studies."

Viewed as an alternative to participation in large, urban ISNs, CISNs may be attractive to many rural providers. State health care reform may also provide opportunities for Minnesota's Indian tribes to address health care delivery and financing issues through participation with local non-Indian providers in CISN's.

IMPACT OF HEALTH CARE REFORM ON INDIAN HEALTH SERVICES

The potential impact of various health care reform proposals on the Indian Health Service and Indian health was the subject of a conference held in February, 1993 at Johns Hopkins University. In a summary of that conference the authors state:

> The primary weakness of the IHS system is its severe underfunding. Less than 50% of the actual level of need documented by IHS is funded through annual appropriations to the agency. The agency has experienced a 40% reduction in real dollars, once adjusted for inflation over the past decade to

> implement authorized and needed services. This has resulted in a rationing of services...(Kauffman and Associates, 1993).

The ability to enroll some Indians in MinnesotaCare would provide needed relief for many of Minnesota's tribal health centers that are now severely underfunded. Although eligibility for most forms of health insurance would render one ineligible for MinnesotaCare, a representative of the Minnesota Department of Human Services indicated that eligibility for the Indian Health Service would not disqualify Indians from applying for MinnesotaCare. However, since MinnesotaCare benefits are intended for primary and preventive care services which are available to most of Minnesota's Indians through tribal health services, few Indians are expected to enroll in MinnesotaCare.

An additional source of non-IHS funding for tribal health services could result from ISNs or CISNs forming in Minnesota under health reform. While there is no direct incentive for non-Indian providers and insurers to infuse funds into tribal health services, some tribes may have sufficient resources to attract the interest of community stakeholders in the formation of an ISN. When resources are pooled in the delivery of health care services to both Indian and non-Indian members of a rural community, tribal funds are combined with other health care dollars. Serving a larger population with an increased revenue base may create opportunities to improve the quality of care to all members of the community.

IHS clinics qualify as Essential Community Providers (ECPs) in Minnesota. Under the current MinnesotaCare legislation, this status will require that any health plan serving the area must use the tribal health service as a provider, and must pay them their current rates. This protection for tribal health services is limited to five years from the date ECP status is granted, at which time an ISN could cancel its contract with a tribal provider.

Some tribal health providers fear that, due to historic underfunding of the IHS, these facilities will not be competitive, and will be excluded from ISNs when their protected status expires. In some isolated regions where IHS clinics are the only available source of care, this could force non-Indian patients living near reservations to travel greater distances for health care.

THE GAMING INDUSTRY

Concurrent with (but unrelated to) the development of health care reform in Minnesota has been the establishment of gambling casinos on Indian land. Tribally operated gambling facilities are a significant source of funds for many of Minnesota's Indian bands. This new source of tribal revenue has been used on several reservations to construct new schools and community centers and for other needed capital projects. The Mille Lacs band of Ojibwe, which operates large casinos in Onamia and Hinckley, for example, has built new schools, a health clinic, three community centers, several new housing units and has installed new water and sewer service in the Onamia area. Their role in the construction of a new clinic in Hinckley, as part of a newly formed integrated service network in east-central Minnesota, will be discussed in some detail below. The influx of revenues from gaming operations has had varying impact on tribal health operations.

While tribal gaming operations in Minnesota have offered hope of some solutions to Indian health care underfunding, this new source of tribal revenue has been accompanied by new problems for Indian health services. Indians who have been living in urban areas, where they receive health services through IHS funded urban health programs, are returning to the reservation to work in the gaming industry. Their return

overloads the existing underfunded health system on those reservations. Often, the employees of the gaming industry are offered health insurance by their employers, but some Indians feel they should not have to pay the employee's share of the premium, since their health care should be provided by the IHS. Thus, a substantial opportunity to complement IHS funds with third party reimbursement may be lost.

TWO EXAMPLES OF NETWORKING ACTIVITIES

Mille Lacs Band of Ojibwe and the I-35 Corridor Health Network

The Mille Lacs band of Ojibwe is one of several Minnesota bands with multiple non-contiguous areas of reservation land. The largest parcel owned by the band is on the western shore of Mille Lacs Lake in central Minnesota near Onamia. A small parcel of land is located approximately 40 miles east, near Hinckley, and another large parcel of land is located approximately 25 miles east of Hinckley, at Lake Lena, near the Wisconsin border. The tribal government and most services are located at the Onamia site. The Lake Lena reservation has a community center with an examining room, but the band has found it impractical to send a physician there on a regular basis. Members of the Mille Lacs band living at the Lake Lena site have been referred to Sandstone (25 miles away) or Mora (46 miles away) for most of their medical care.

In 1992, the Mille Lacs band opened a casino on their Hinckley property. Hinckley is located on Interstate Highway 35 half-way between Duluth and the Twin Cities. Since the opening of the interstate highway in the 1960's, several businesses have developed near the Hinckley freeway exit, catering to motorists traveling between the two metropolitan areas. The Grand Casino has provided a windfall for the Mille Lacs band, as well as the Hinckley community. Several new hotels and restaurants have opened in the

area, and 1200 new jobs are now provided at the casino, with additional new jobs in the surrounding community (see Figure 1).

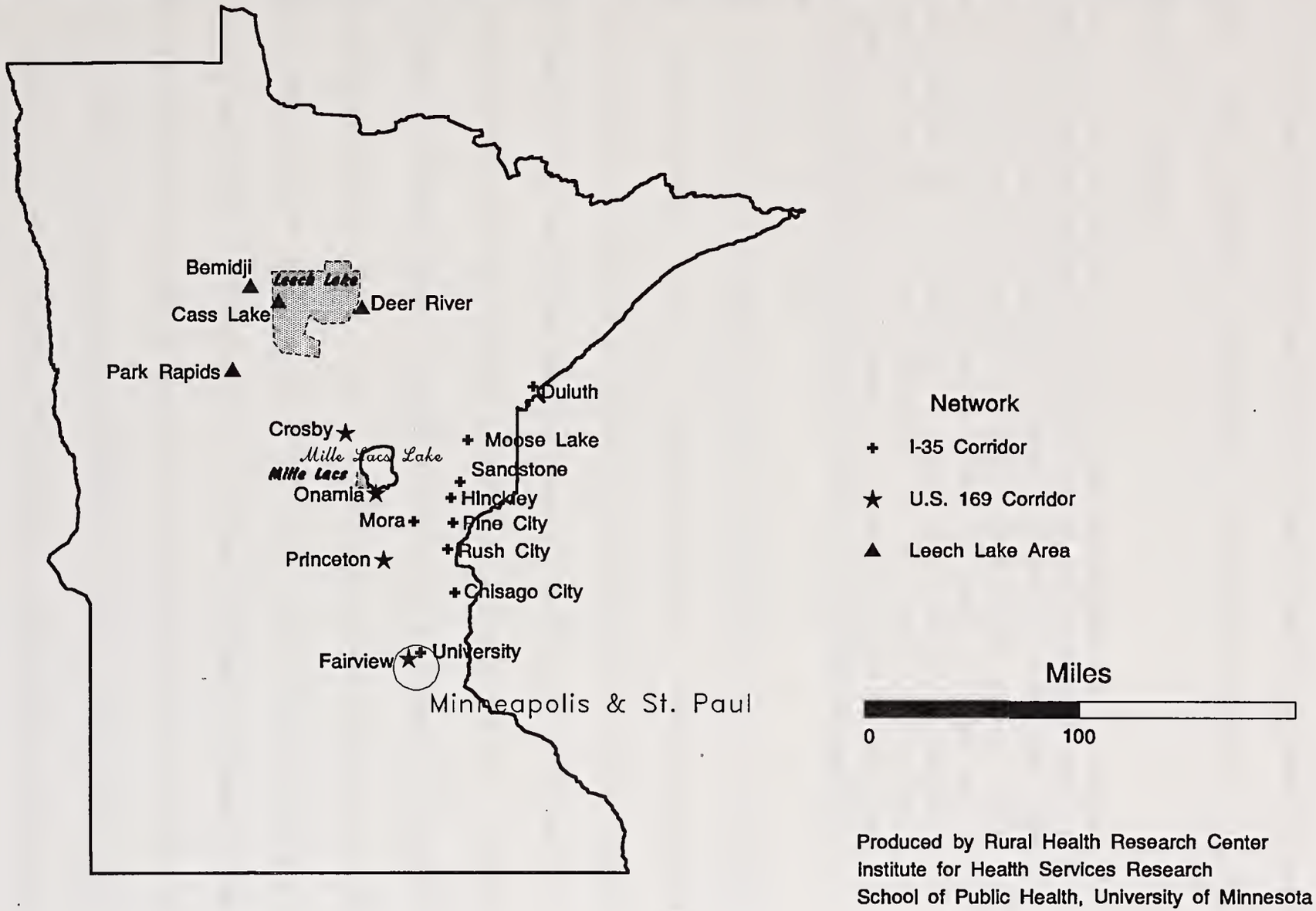
Hinckley does not have a hospital. Local hospital services are available at Sandstone (nine miles to the north). Ambulatory care is provided at a one-physician satellite clinic staffed from a primary clinic in Mora (21 miles to the southwest). With population growth resulting from the casino, some members of the community hoped to recruit one or more full-time physicians and increase the staff at the clinic. At the same time, the Mille Lacs band hoped to improve services both to band members living and working in Hinckley, and to those living on the Lake Lena part of the reservation, twenty-five miles east of Hinckley. These needs, combined with the substantial amount of capital at the disposal of the Mille Lacs band, created an opportunity for cooperation between the Indian and non-Indian communities. In addition, the Minnesota legislation encouraging formation of ISNs and CISNs stimulated interest in collaborative activities on the part of non-Indian physicians and hospitals.

Members of the Mille Lacs band approached the University of Minnesota Department of Family Practice and Community Health in October, 1992 for help in building and staffing a new clinic in Hinckley. The University had an existing arrangement with the Minnesota Center for Rural Health (MCRH) in Duluth to provide assistance with physician recruitment, shared services, and other network development to rural communities. Since the clinic would affect all providers in the area, MCRH organized discussions with physicians and hospital administrators from the surrounding communities of Moose Lake, Rush City and Sandstone. Eventually, this group expanded to include representatives from other communities along Interstate 35 between the Twin Cities and

Figure 1

MINNESOTA

Rural Networks Serving American Indians (Active and Planned)



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Duluth. Early in 1993, the I-35 Corridor Health Care Project was officially launched, and a memorandum of agreement and a vision statement were signed by representatives of most of the communities, providers, and hospitals. The vision statement outlines the goals of the network. It states:

> Participants in the I-35 Corridor Health Network share the common vision of developing a formally organized, fully integrated and coordinated network of health care services that provide a continuum of cost effective, high quality care. These services, including prevention, wellness, primary care, inpatient, ambulatory and long-term care, shall be made available to the population served by the Network (a rural area extending between Minneapolis/St. Paul on the south and Duluth on the north, and east-west along I-35), in a convenient, humane and culturally-sensitive manner. Needed specialty services that cannot be provided in the area will be made available in tertiary care centers.

The I-35 Corridor Health Care Network applied for 501(C)(3) status, with members of the steering committee initially serving as the governing board. Participating network members include: hospitals and clinics located in Moose Lake, Sandstone, Mora, Pine City, Rush City and Chisago City, as well as the new clinic in Hinckley. The University of Minnesota Hospital and Clinics will provide management services and tertiary care, and will play a role in physician recruitment. The Mille Lacs band will not have a seat on the governing board of this network initially, since it has not completed construction of the clinic in Hinckley. However, the staffing plan for the new clinic includes coverage by physicians from the surrounding member clinics. Planned network activities include: group purchasing, shared services, provider education, coordinated physician recruitment and retention, community wellness programs provided through joint ventures with public health agencies, continuous quality improvement activities, a health plan for self-insured employers, and a health risk assessment for the population in the service area.

Although construction of the new clinic in Hinckley is not a project of the network, development of the clinic and the network have been linked since the first network meeting in January, 1993. The Mille Lacs band of Ojibwe signed a letter of understanding with the University of Minnesota to provide management services for the new clinic. The letter of understanding also indicates that the University will provide assistance in the recruitment of additional physicians. The University will also provide visiting medical specialty services to the Hinckley clinic, as well as to the Pine City and Rush City members.

Following their involvement with the I-35 Network, the Mille Lacs band is now working on the development of a similar network to improve services to their members living near Mille Lacs Lake. They are coordinating efforts with area hospitals in Crosby, Princeton and Onamia, and with the Fairview hospital system in the Twin Cities.

Leech Lake Band of Ojibwe Networking Activities

The Leech Lake band of Ojibwe differs from the Mille Lacs band in two significant ways. First, the Leech Lake band is one of the three Minnesota Indian bands that continues to have hospital and clinic services provided directly by the IHS. The tribal health department also provides a range of health services under a 638 contract with IHS[2]. In contrast, the Mille Lacs band, after several years of 638 contracting, now operates its health services under self-governance authority. Second, Leech Lake is more

[2]These services include several nutrition programs including Women,Infants and Children (WIC), emergency medical and public health nursing services, community health representatives, chemical dependency, mental health, diabetes, environmental health, exercise/fitness, and family planning.

distant from the Twin Cities than the Mille Lacs band, limiting its opportunities for networking with tertiary care hospitals.

In 1992, the Indian Health Service invited applications for Health Care Delivery Demonstration Projects for American Indians and Alaska Natives under section 307 of the Indian Health Care Improvement Act. Tribes or tribal organizations were asked to propose health care delivery demonstration projects to test alternative means of delivering health care and services through health facilities. Nine IHS service units were targeted as "priority one," with the requirement that a contract or grant must be awarded to a tribe or tribal organization that presents an acceptable application from each of these areas before awards may be made to any other service unit. Leech Lake was on the list of nine service units (Radke, 1993).

The University of Minnesota Rural Health Research Center (UMRHRC) helped tribal representatives identify a variety of resources to assist them in preparing their application. That application was submitted in January of 1994, with a letter of support from UMRHRC. The amount of networking activity proposed in the application is small when compared with the I-35 Corridor Network. Letters of support were obtained from area hospitals in Bemidji, Deer River and Park Rapids, with a commitment to avoid duplication of services. Like the Mille Lacs band, there is an effort to improve the cultural sensitivity of other area health care providers, and there are plans for regular meetings with area providers to discuss operations and evaluations of service delivery for the region. At the present time, there is no indication of shared governance, joint strategic planning, shared services, or any of the other formal network activities pursued by the I-35 Corridor

Network. However, with the establishment of regular meetings with area providers, the possibility of more formal networking is enhanced.

CONCLUSIONS AND IMPLICATIONS FOR OTHER RURAL INDIAN TRIBES

It seems likely that two important differences between the Mille Lacs band and the Leech Lake band may account for the variation in their approaches to health care reform. First, the Leech Lake band traditionally has had more of its health services provided directly by the IHS. It has had limited self-governance and 638 contracting experience, although it is currently pursuing more self-governance options. While some Indian bands or tribes deal frequently with area providers under 638 contracting, direct services bands such as Leech Lake are likely to have fewer interactions with the non-Indian health system, and are therefore less likely to join with those providers in forming new network relationships. Second, while the Mille Lacs sites at Onamia and Hinckley are, respectively, 100 miles and 80 miles distant from the Twin Cities, Leech Lake is nearly 200 miles from the metro area. By helping the Mille Lacs band identify appropriate participants in planning their new clinic, the outreach efforts of the University of Minnesota Hospital and Clinics played a role in the progress of the Mille Lacs networking activities. Similarly, outreach from the Fairview hospital system may facilitate development of a western Mille Lacs network. Such outreach efforts have not penetrated the region where the Leech Lake reservation is located. Physicians and hospitals in Duluth are in the process of forming an ISN, and have begun to develop an outreach program in northern Minnesota. This network may eventually reach out to the Leech Lake reservation.

If the I-35 Corridor Health Network results in improved health services in Hinckley, it appears likely that it will also result in improved health services for the Mille Lacs

Indians living near Hinckley. Locally available medical practitioners will likely decrease the distance many band members travel for health services. The effect of network participation on the financing of the Mille Lacs band's health services is not known at this time. Profits from the gaming industry have not been used for clinic operations or to pay insurance premiums,[3] but it is hoped that availability of these funds for capital and construction will create a health services environment in which IHS self-governance funds go further in providing needed health care to tribal members.

It is clear from the I-35 Corridor experience that the presence of certain factors improve the likelihood that Indian tribes or organizations will be able to take advantage of health care reform. First, the group should have some experience with operating its own health services and should be familiar with area providers. Second, involvement of non-local entities such as a tertiary care hospital or an academic institution can help in identifying resources and establishing contacts with area providers. Finally, the Indian group must have something to offer to other network members. In this case, profits from the casinos made it possible for the Mille Lacs band to bring financial resources to the bargaining table. An additional factor that may explain the difference between the Mille Lacs and Leech Lake experiences is the geographic characteristics of the areas. Lower population density, greater distances between towns, and lack of a major highway are factors that distinguish the Leech Lake area from the Mille Lacs area. Despite their potentially greater need, geographically isolated reservations may have greater difficulty developing network relationships than those in less remote regions. Our future work will

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[3]Some tribes in Minnesota have chosen to allocate gaming profits directly to their members in the form of monthly profit-sharing checks. It may be that the strategy chosen by the Mille Lacs band reflects a reluctance to have health service availability dependent upon gaming profits.

examine the I-35 corridor health network in greater detail, as part of an ongoing study of integrated health networks serving rural populations.

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